The Tulalip Tribes of Washington Employee Health Benefit Plan: Gold Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 11/01/2015 – 12/31/2016

Coverage for: Individual, Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.accesshma.com or by calling **1-800-700-7153**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** individual / **$1,500** family for In-Network. **$750** individual / **$2,250** family for Out-of-Network. Doesn't apply to In-Network office visits, preventive services, and urgent care visits. Doesn't apply to In-Network and Out–of-Network alternative medicine, chiropractic services, durable medical equipment less than $500, dental services, dietary education, flu shots, and immunizations.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,000** individual / **$9,000** family for In-Network. **No limit** for Out-of-Network.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, penalties, ineligible charges, prescription copays, balance-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.accesshma.com or call 1-800-700-7153** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

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Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Tulalip Health Clinic **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		In-Network	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	40% co-insurance	——————none——————
	Specialist visit	$20/visit	40% co-insurance	——————none——————
	Other practitioner office visit	$20/visit for chiropractic care; 25% co-insurance for alternative services		Alternative services and chiropractic care limited to 12 visits per calendar year.
	Preventive care/screening/immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance	10% co-insurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% co-insurance	10% co-insurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network	Your Cost If You Use a Out-of-Network	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$8/prescription (retail); Not covered (mail order)	$15/prescription (retail); $30/prescription (mail order)	Covers up to a 34-day supply of non-maintenance drugs and a 90-day supply (3 co-pays) of maintenance drugs (retail prescription); 90-day supply (mail order prescription). See Plan Document for non-use of generic drug penalty.
	Preferred Brand drugs	$15/prescription (retail); Not covered (mail order)	$30/prescription (retail); $60/prescription (mail order)	
	Non-preferred Brand drugs	$30/prescription (retail); Not covered (mail order)	$50/prescription (retail); $100/prescription (mail order)	
	Specialty drugs	Contact Caremark, your prescription drug vendor, for applicable cost.		Please see Prescription Drug Benefit section within your Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	40% co-insurance	Pre-authorization is required.
	Physician/surgeon fees	10% co-insurance	40% co-insurance	——————none——————
If you need immediate medical attention	Emergency room services	$350 copay, then 10% co-insurance	$350 copay, then 10% co-insurance	Co-pay waived if admitted.
	Emergency medical transportation	10% co-insurance		——————none——————
	Urgent care	$20/visit	$20/visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$100/day ($500 limit per admit); 10% co-insurance	40% co-insurance	Co-pay waived if readmitted within 90 days. Pre-authorization is required.
	Physician/surgeon fee	10% co-insurance	40% co-insurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		In-Network	Out-of-Network	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20/visit	40% co-insurance	Marital, family, and sexual counseling not covered, unless with a mental health diagnosis.
	Mental/Behavioral health inpatient services	$100/day ($500 limit per admit); 10% co-insurance	40% co-insurance	Pre-authorization is required. Residential treatment is covered.
	Substance use disorder outpatient services	$20/visit	40% co-insurance	——————none——————
	Substance use disorder inpatient services	10% co-insurance	40% co-insurance	Pre-authorization is required. Residential treatment is covered.
If you are pregnant	Prenatal and postnatal care	10% co-insurance	40% co-insurance	——————none——————
	Delivery and all inpatient services	$100/day ($500 limit per admit); 10% co-insurance	40% co-insurance	Pre-authorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need help recovering or have other special health needs	Home health care	10% co-insurance	40% co-insurance	Limited to 130 visits per calendar year. Pre-authorization is required.
	Rehabilitation services	10% co-insurance (outpatient); $100/day ($500 limit per admit), 10% co-insurance (inpatient)	40% co-insurance	Pre-authorization is required for inpatient services.
	Habilitation services	10% co-insurance	40% co-insurance	Neurodevelopmental therapy only; limited to age 7.
	Skilled nursing care	10% co-insurance	40% co-insurance	Limited to 30 days per calendar year. Pre-authorization is required.
	Durable medical equipment	20% co-insurance		Pre-authorization is required if over $1,000.
	Hospice service	10% co-insurance	40% co-insurance	Pre-authorization is required. Limited to 6 month lifetime max.
If you or your child needs dental or eye care	Eye exam	No charge (to age 5); $ 10 copay (age 5 & over)		——————none——————
	Glasses	$20 copay		No max (to age 19); limited to $300 every 2 calendar years (over age 19). Contact exam/fitting has a $25 copay.
	Dental check-up	Covered for children to age 5.		

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery (unless medically necessary)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Dental care (Adult and Child)
- Routine eye care (Adult)
- Routine eye care (Child)
- Private-duty nursing (for transplant services)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-425-462-1000 or 1-800-869-7093. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Plan at 1-425-462-1000 or 1-800-700-7153. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-700-7153.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-700-7153.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**800-700-7153.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-700-7153

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,220
- **Patient pays** $2,320

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$220
Coinsurance	$610
Limits or exclusions	$490
Total	**$2,320**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,140
- **Patient pays** $1,260

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$140
Copays	$1,020
Coinsurance	$20
Limits or exclusions	$80
Total	**$1,260**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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